CALIFORNIA VCGCB
Victim Compensation & Government Claims Board

ASSOCIATED APPLICATION ID:
Enter if known
A -

Application For Crime Victim Compensation

Section 1 must be completed for all applications. If you are filing this application on behalf of someone else, put their information in Section 1 and your information in Section 3. Please print clearly and complete all sections that apply.

☐ **Check This Box if You Are a Parent/Guardian Applying on Behalf of a Minor Witness to Violent Crime.** Minor witnesses are eligible for mental health treatment only. Claimant is under age 18, a witness in close proximity to a violent crime, but is neither the crime victim nor related to the victim. Provide available victim, crime or other information in all sections.

Example:
FIRST NAME: First
LAST NAME: Last

Section 1 Claimant

SECTION 1 MUST BE COMPLETED FOR ALL APPLICATIONS
A separate application must be filed for each person seeking assistance.
The claimant is the person who has expenses or is seeking assistance as a result of a crime.

FIRST NAME:

MIDDLE NAME:

LAST NAME:

SOCIAL SECURITY NUMBER: ___ – ___ – ____

Does the claimant have a Social Security number? ☐ Yes ☐ No

DATE OF BIRTH (MM/DD/YYYY): ___ / ___ / ____

GENDER: ☐ M ☐ F

Relationship to victim: ☐ Self ☐ Other If other, describe:

From the date of the crime to the present, has the **claimant** been in prison, on probation, or on parole because of a felony? ☐ Yes ☐ No

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX:

Address 2 (Apartment or Unit #):

CITY:

STATE:

ZIP:

HOME TELEPHONE: ___ – ___ – ____

WORK TELEPHONE: ___ – ___ – ____ Ext.

CELL PHONE: ___ – ___ – ____

E-MAIL:

If you are an adult victim and the expenses are for you, skip to Section 4. If not, continue to Section 2

ENG

For more information call: **1.800.777.9229**

Hearing impaired, please call the California Relay Service (711)

www.victimcompensation.ca.gov

Mail completed application to:
R. SCOTT OWENS
Placer County District Attorney
10810 Justice Center Drive, Ste. 240
Roseville, CA 95678

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Section 2 Crime Victim

The crime victim is the person who was injured, threatened with injury, or killed due to the crime.

FIRST NAME: MIDDLE NAME:

LAST NAME: SOCIAL SECURITY NUMBER: – –

DATE OF BIRTH (MM/DD/YYYY): / /

GENDER: M F

Does the victim have a Social Security number? Yes No

From the date of the crime to the present, has the **victim** been in prison, on probation, or on parole because of a felony? Yes No

IF VICTIM IS DECEASED, DATE OF DEATH: / /

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Apartment or Unit #):

CITY: STATE: ZIP:

HOME TELEPHONE: – –

WORK TELEPHONE: – – Ext.

CELL PHONE: – –

E-MAIL:

If you are completing this application on behalf of a minor or an incapacitated adult, continue to Section 3
If not, skip to Section 4

Section 3 Parent or Guardian (Applicant)

This section is for parents or guardians of minors or incapacitated adults listed in Section 1.
Relationship to the person listed in Section 1:

Parent Guardian Social Worker Other, describe:

FIRST NAME: MIDDLE NAME:

LAST NAME: SOCIAL SECURITY NUMBER: – –

DATE OF BIRTH (MM/DD/YYYY): / /

GENDER: M F

Do you have a Social Security number? Yes No

From the date of the crime to the present, have **you** been in prison, on probation, or on parole because of a felony? Yes No

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Apartment or Unit #):

CITY: STATE: ZIP:

HOME TELEPHONE: – –

WORK TELEPHONE: – – Ext.

CELL PHONE: – –

E-MAIL:

Continue to Section 4

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Section 4 Information About Your Expenses

For the victim of the crime, the following benefits may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

- ☐ Medical and/or dental expenses
- ☐ Mental health treatment
- ☐ Income loss (if you missed work because of the crime)
- ☐ Moving or relocation expenses
- ☐ Home security improvements
- ☐ Home or vehicle modifications (for a victim disabled because of the crime)
- ☐ Job retraining (for a victim disabled because of the crime)
- ☐ Crime scene clean-up
- ☐ Other: _____

For someone other than the victim of the crime, the benefits below may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

For minor witnesses to violent crime, only mental health benefits are available. Proceed to Section 5.

- ☐ Mental health treatment
- ☐ Wage loss (up to 30 days if a minor dies or is hospitalized)
- ☐ Loss of support (for dependents of a deceased or disabled victim)
- ☐ Funeral and/or burial expenses
- ☐ Crime scene clean-up
- ☐ Home security improvements
- ☐ Medical expenses for a deceased victim

Continue to remaining sections

EMERGENCY AWARD REQUEST:

Emergency awards may be requested in certain situations. An emergency award is intended to pay for crime-related expenses in cases where you will suffer serious financial hardship if crime-related expenses are not immediately paid. Substantial hardship means you would not have any money left for necessities like food or rent after you paid for crime-related bills. Qualifying emergency awards are generally paid within 30 calendar days pf receipt of the application.

Do you need to request an emergency award? ☐ Yes

Section 5 Crime Information

Law Enforcement Agency Name:

NAME OF THE LAW ENFORCEMENT AGENCY TO WHICH THE CRIME WAS REPORTED:
(Includes Child Protective Services)

Date(s) crime occurred

FROM: (If on one day only, enter date here) TO: DATE CRIME WAS REPORTED:

TYPE OF CRIME:

DESCRIBE INJURIES: _____

LOCATION OF CRIME: (if known) Address, Intersection, Area, etc:

CRIME REPORT NUMBER:

COUNTY WHERE CRIME OCCURRED:

Person who committed the crime (suspect), if known:

FIRST NAME:

MIDDLE NAME:

LAST NAME:

☐ Suspect Unknown

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Section 6 Representative Information (A representative is not needed to apply for victim compensation.)

This section is for representatives only, including victim advocates and attorneys. Victim Assistance Center Advocates need only provide phone, name, center #, sign and date. Attorneys, please fill out this section completely.

FIRST NAME:

MIDDLE NAME:

LAST NAME:

TELEPHONE: ___ – ___ – ____

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX:

Address 2 (Suite #):

CITY:

STATE:

ZIP:

ORGANIZATION NAME:

Representative's signature:	Date:

VICTIM WITNESS ASSISTANCE CENTER NAME:

PLACER COUNTY DIST. ATTY.

JP/VWC #: 63

For Attorneys Only:

State Bar Number:

Federal Tax ID:

Are you requesting payment pursuant to Government Code Section 13957.7(g)? ☐ Yes ☐ No

Section 7 How Did You Find Out About the Program?

- ☐ Law Enforcement
- ☐ District Attorney
- ☐ Medical Provider
- ☐ Card or Booklet
- ☐ Child Protective Services
- ☐ Adult Protective Services
- ☐ Media (TV, Radio, Newspaper, etc.)
- ☐ Other: _____
- ☐ Mental Health Provider
- ☐ Victim Witness Assistance Center
- ☐ Billboard or Poster

Section 8 Federal Reporting Information

The following **voluntary** information is for the **person receiving compensation** and is used for statistical purposes only to comply with federal regulations.

Ethnicity:

- ☐ African American
- ☐ Caucasian
- ☐ Asian, Pacific Islander
- ☐ Native American
- ☐ Hispanic
- ☐ Other: _____

Is the victim disabled? ☐ Yes ☐ No

Was the victim disabled prior to the crime? ☐ Yes ☐ No

Section 9 Insurance Information

Please check all available sources that could be applied to your claim. The Victim Compensation Program is the payer of last resort. We may contact your insurance company as a potential reimbursement source. List insurance contact information below or on an additional sheet and attach.

☐ Health ☐ Medi-Cal ☐ Medicare ☐ Auto ☐ Workers' Compensation ☐ Homeowners/Renters ☐ None ☐ Other: _____

INSURANCE COMPANY NAME: TELEPHONE: ___ – ___ – ____

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Suite #):

CITY: STATE: ZIP:

Name of Insured:

FIRST NAME: MIDDLE NAME:

LAST NAME:

POLICY NUMBER: GROUP NUMBER:

Have you filed an insurance claim related to this crime? ☐ Yes ☐ No ☐ Undecided

Section 10 Employer Information

Please list the victim's employer. If you are a parent/guardian seeking wage loss benefits because a minor victim was hospitalized or is deceased, list your employer.

EMPLOYER'S BUSINESS NAME:

Contact Person:

FIRST NAME: OK to contact employer? ☐ Yes ☐ No

LAST NAME: TELEPHONE: ___ – ___ – ____

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Apartment or Suite#):

CITY: STATE: ZIP:

Is or was the victim self-employed? ☐ Yes ☐ No

Did the victim miss work as a result of crime-related injuries? ☐ Yes ☐ No

Did the crime occur while the victim was on the job or at the workplace? ☐ Yes ☐ No

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Section 11 Civil Suit Information

Have you filed, or do you plan to file, a civil suit related to this crime? ☐ Yes ☐ No

Note: If you decide to file a civil suit, by law, you are required to notify the Victim Compensation Program within 30 days of filing the action.

Attorney's Name:

FIRST NAME:

MIDDLE NAME:

LAST NAME:

TELEPHONE: ___ – ___ – ____

Mailing Address:

STREET NUMBER AND NAME OR P.O. BOX:

Address 2 (Suite #):

CITY:

STATE:

ZIP:

Your application for crime victim compensation is almost complete

- After entering all available information, print the application.
- Attach copies of any documentation that supports your application for crime victim compensation, including copies of crime-related bills, insurance, or anything relating to the crime. Save original documents for your records.
- Please read the next page carefully, sign and date, and send to the address indicated or deliver to your local Victim Witness Assistance Center.
- The Victim Compensation Program (CalVCP) will send you a letter acknowledging that your application has been received. The acknowledgment letter will include additional information about the benefits requested on your application.
- A CalVCP representative may contact you for additional information if you were not able to provide it with your application.
- For any questions about Victim Compensation, you can contact your local Victim Witness Assistance Center or call 1-800-777-9229.

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This page MUST be signed and dated

Section 12 Information Release

I give permission to any healthcare provider; any medical biller, any funeral director or similar persons, any employer, any police or other government agency, including the Department of Justice, the Social Security Administration, the State Franchise Tax Board, and the Federal Internal Revenue Service; any insurance company; or any other person or agency, to provide information relating to this application, including medical (including, but not limited to history or physical records, consultation reports, pathology reports, discharge summaries, operative reports, X ray and other radiology reports, laboratory reports, chart notes, narrative reports, and billing records), mental health, and felony conviction records, to the California Victim Compensation Program (CalVCP) or its representatives, for the purpose of determining eligibility for CalVCP benefits. This permission also applies to all sources of recovery for the claimed losses, including but not limited to, health or medical benefits, unemployment or disability benefits, Social Security benefits (Social Security disability, Supplemental Security income, and/or retirement, including the supporting medical and/or mental health records), and Veteran benefits. I also give permission for the release of federal and state tax information, including tax returns, for the purpose of verifying income. I hereby waive all legal privileges to any of this information required by CalVCP regarding my claim.

I agree that a photocopy or fax of this signed form is as valid as the original, and my signature gives permission for the release of all specified information.

I agree that CalVCP or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me by CalVCP and that by filing this application I have authorized use of information in this application and subsequent claim files to pursue restitution from the convicted offender.

In order to verify or process this application, I agree that CalVCP or its representatives may provide information about this application, and the information contained in this application, to any representative named on this application, government agency, or health care provider or other provider of services, and may pay the provider directly if payment of these services is approved.

I agree that I may revoke this authorization at any time. The revocation must be in writing. The revocation will take effect when CalVCP receives it, but I may be deemed ineligible for CalVCP benefits once the revocation is received by CalVCP. However, no healthcare provider may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this authorization except in limited circumstances. I agree that information disclosed under this authorization may be redisclosed by the recipient as required by law and this redisclosure may no longer be protected by federal or state law.

I agree that the authorizations and agreements herein will expire ten (10) years after the date of my signing this form.

Signed:	**Date:**

(Parent or guardian must sign if victim is a minor or incapacitated.)

Section 13 My Agreement to the California Victim Compensation Program

As required by California law, I will contact and repay the California Victim Compensation Program if I, or anyone on my behalf, receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from the Program, in the amount of the total benefits granted by the Program. I understand I may be responsible for repaying the Victim Compensation Program any amount for which it is later determined that I was not eligible. I will notify the Victim Compensation Program if I hire an attorney to represent me in any action related to this crime or if I pursue any action on my own.

Any monies I receive from the California Victim Compensation Program for moving/relocation expenses, improving home security, or for modifying a home or vehicle for a disabled victim will be used only for those purposes. If I am a victim of domestic violence receiving moving/relocation expenses, I will not tell the offender my home address nor allow the offender on the premises at any time, or I will seek a restraining order against the offender.

In the event that I am compensated for any pecuniary loss by the California Victim Compensation Program and the State of California subsequently receives compensation for the same loss on my behalf from the perpetrator (including any monies received through a restitution order) or from any other source, I hereby assign to the Victim Compensation and Government Claims Board any and all rights to such duplicate compensation.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that I may be found to be ineligible for benefits, and that action may be taken to recover benefits I receive if I provide information that is false, intentionally incomplete, or misleading.

Signed:	**Date:**

(Parent or guardian must sign if victim is a minor or incapacitated. County social workers, see section 13a.)

Printed Name:

Section 13a For County Social Workers Only

As required by California law, I will contact and inform the California Victim Compensation Program if I learn the minor claimant receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from the Program.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that I may be found to be ineligible for benefits, and that action may be taken to recover benefits I receive if I provide information that is false, intentionally incomplete, or misleading.

Signed:	**Date:**

Printed Name:

Mail completed application to:
Victim Compensation & Government Claims Board
PO Box 3036, Sacramento, CA 95812-3036

- or -
deliver to your local **Victim Witness Assistance Center**

For more information call:
1-800-777-9229
Hearing impaired, please call
the California Relay Service (711)

Helping California Crime Victims Since 1965 ***www.victimcompensation.ca.gov***